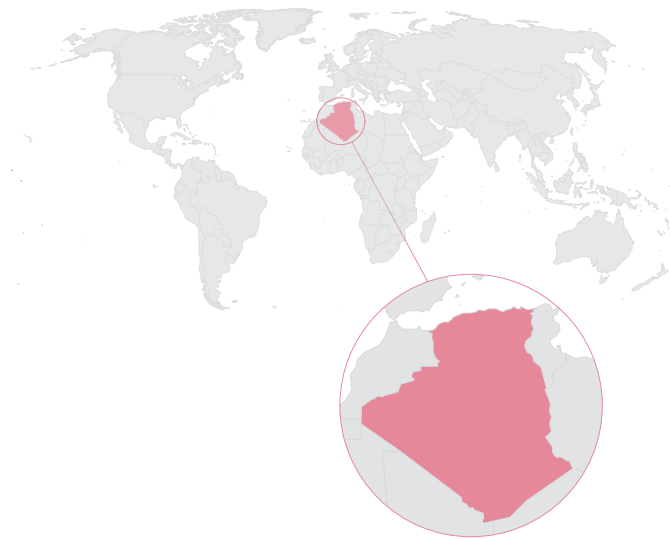


CRC 1342 | No. 28

# Social Policy Country Briefs

Algeria



Brahim Brahamia

## The Health Care System in Algeria



Global Dynamics  
of Social Policy CRC 1342



Deutsche  
Forschungsgemeinschaft

**Brahim Brahamia**

The Health Care System in Algeria

CRC 1342 Social Policy Country Briefs, 28

Edited by Johanna Fischer

Bremen: CRC 1342, 2022



SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /  
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-  
term care as a new social risk

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<https://www.socialpolicydynamics.de>

[DOI <https://doi.org/10.26092/elib/2028>]

[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft

(DFG, German Research Foundation)

Projektnummer 374666841 – SFB 1342

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# THE HEALTH CARE SYSTEM IN ALGERIA

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Brahim Brahamia

## *Content*

1. COUNTRY OVERVIEW . . . . .	3
2. SELECTED HEALTH INDICATORS . . . . .	3
3. LEGAL BEGINNING OF THE SYSTEM . . . . .	4
4. CHARACTERISTICS OF THE SYSTEM AT INTRODUCTION . . . . .	4
a. Organisational structure . . . . .	4
b. Coverage . . . . .	5
c. Provision . . . . .	5
d. Financing . . . . .	5
e. Regulation . . . . .	6
5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTH CARE . . . . .	6
a. Major reform I . . . . .	6
b. Major reform II . . . . .	6
c. Major reform III . . . . .	7
6. DESCRIPTION OF CURRENT HEALTH CARE SYSTEM . . . . .	8
a. Organisational structure . . . . .	8
b. Provision . . . . .	8
c. Financing . . . . .	8
d. Regulation of dominant system . . . . .	9
7. CO-EXISTING SYSTEMS . . . . .	9
8. ROLE OF GLOBAL ACTORS . . . . .	9
9. LIST OF ADDITIONAL RELEVANT LEGAL ACTS . . . . .	10
REFERENCES . . . . .	10

## 1. COUNTRY OVERVIEW



Source: <https://www.populationdata.net/cartes/algerie-divisions-administratives/> (Accessed: September 7, 2022)

- » Sub-Region: Northern Africa
- » Capital: Algiers
- » Official Language: Arabic
- » Population size: 44.1 million (2020, World Bank)
- » Share of rural population: 26.81 % (2019, World Bank)
- » GDP: US\$ 144.9 billion (2020, World Bank)
- » Income group: Lower-Middle Income (World Bank 2020)
- » Gini Index: 27.6 (2020, World Bank)
- » Colonial period: 11830–1962 French colony
- » Independence: July 5, 1962

## 2. SELECTED HEALTH INDICATORS

Indicator	Algeria	Global Average
Male life expectancy (2018)	75.49	70.2
Female life expectancy (2018)	77.94	74.7
Under-5 mortality rate (2019)	23.3 per 100,000 live births	38 per 100,000 live births
Maternal mortality rate (2017)	112 per 100,000 live births	211 per 100,000 live births
HIV prevalence (2019)	0.1 % (15-49 age range)	0.7% (15-49 age range)
Tuberculosis prevalence (2019)	61 per 100,000 people	130 per 100,000 people

Source: <https://data.worldbank.org/topic/health?locations=DZ>

### 3. LEGAL BEGINNING OF THE SYSTEM

Name and type of legal act	Ordonnance n° 73-65 du 28 décembre 1973 portant institution de la médecine gratuite dans les secteurs sanitaires (Ordonance no. 73-65 of De-cember 28, 1973 establishing free health care in the health sectors)
Date the law was passed	December 28, 1973
Date of <i>de jure</i> implementation	January 1, 1974
Brief summary of content	With this ordinance the political authorities attempted to improve health and well-being of citizens through the establishment of free health care access, which is realized as free medical services provided in public health care facilities and hospitals. Health sector budgets are financed by the state budget. Access to public facilities is free for all citizens regardless of their status or income.
Socio-political context of introduction	After 132 years of colonization and more than 7 years of devastating national liberation war, at independence in 1962, Algeria inherited a health system highly concentrated in the main northern urban cities, but deprived of its human resources after the European health practitioners had left the country (Brahamia 1991). The social and health conditions of the population were deplorable. By removing the financial obstacle to access to health care in 1974, the public authorities intended to improve the health status of the population, while the country clearly lacked doctors. This measure was part of the democratic opening of the regime leading to the adoption of the Na-tional Charter and Constitution in 1976.

### 4. CHARACTERISTICS OF THE SYSTEM AT INTRODUCTION

#### a. Organisational structure

The health system reflected significant regional disparities. The vast majority of health services were concentrated in the northern cities where many European citizens lived. Nearly 75% of the population was rural and lacked adequate health services. In 1962 Algeria had only 342 Algerian doctors for a population of 10.3 million. There were no universities to train practitioners, and medical coverage relied on the contribution of foreign cooperating doctors coming from all over the world.

Before the introduction of the health system, health care expenditures had to be covered privately and the poor were treated in Free Medical Assistance dispensaries (Oufriha 1992).

In 1963, the National Institute of Public Health was created to deal with prevention and the assessment of the health needs of the inhabitants. In 1966 physicians working in the public health services were allowed to work half their time in private capacity.

At the central level responsibility lay with the Ministry of Health, at the local level with a Departmental Health Directorate. The municipality was in charge of Free Medical Assistance to indigent people.

Eligibility: During the first decade after independence the health situation was precarious and the vast majority of population was excluded from access to health care. Access to care in public health structures required private out-of-pocket payments. Salaried workers benefited from social security coverage if they were affiliated with an insurance organization or belonged to the family of martyrs and the *mojahedin* (former fighters of the national liberation war). Indigent patients were treated for free.

Only after the Ordinance no 73-65 of 28 December 1973 came into force in 1974 (reconfirmed in the health law of 1985; Loi n° 85-05) health care became available for significant parts of the population. The law stipulates that patients benefit from health care in public health care facilities and are treated for free. Each patient became entitled to all medical treatment that his/her case requires, e.g. examination, diagnosis, hospitalization, and medication. Outpatient are treated free of charge and receive free access to necessary drugs. Algeria, having adhered to the recommendations of the Alma Ata conference in 1978, adopted the principle of primary health care. The health system consists of three levels. At its base are primary care services (polyclinics, health centers, maternal and child protection), at the intermediate levels the general hospitals, and at the highest level the specialised hospitals and university hospitals (Kaddar 1989).

## b. Coverage

The 1973 ordinance established free health care for the entire population. Population coverage in the table below reflects the parafiscal nature of the social security funding; funding from contributions benefits contributors and their families and the entire non-contributory population. The state budget pays for special categories: the disabled, students, the inactive, the families of the Mujahideen, etc. Social security funds are considered public funds such as those coming from government budget.

Share of population covered by government schemes	15 %
Share of population covered by the parafiscal social insurance scheme	85 %
Percentage of population covered by private schemes	negligible
Percentage of population uncovered	-

## c. Provision

Number of public hospitals: 1962: 156; 1984: 173; 13 university hospitals.  
Also, a negligible number of private for-profit medical clinics existed.

	Density of medical providers					
	1962			1984		
	Total number	per 1000 inhabitants	Algerians	Total number	per 1000 inhabitants	Algerians
Physicians	1279	0.128	342	1,2132	0.573	9,106
Dentists	151 (1963)	0.014	36 (1963)	2,436	0.115	2,319
Pharmacists	264 (1963)	0.020	70 (1963)	1,286	0.061	1,226
Nurses	3,522 (1963)	0.33	-	54,167	2.57	
Public hospital beds	42,787	4.2		50,210	2.38	

Source: ONS (1987)

In 1962 the health care system consisted of a predominantly public hospital sector with 156 hospitals, increasing to 173 in 1984. In 1962, the public outpatient sector had 188 health centres and dispensaries. In 1984, there were 914 health centres and 285 polyclinics. In 1962 the number of private practitioners was very low, increasing to 1940 private outpatient offices in 1984.

## d. Financing

	1979 (%)	1984 (%)
Health expenditure (% of GDP)	3.5	4.4
State budget	32.9	21.3
Social Security	38.5	53.8
Households (out of pocket)	25.9	22.7
Other	2.7	2.2

Source: Oufriha (1992: 154)

## e. Regulation

The regulation of the health system is the responsibility of the following ministries:

- » The Ministry of Health is responsible for the organization of the health care system, and for the distribution of health resources in the Wilayat (provincial administrative district).
- » The Ministry of Finance is responsible for financing by granting an annual budget allocation to health structures, imposing expenditure control.
- » The Ministry of Higher Education is responsible for the training of health practitioners, in coordination with the Ministry of Health it is responsible for the evaluation of needs of the medical profession.
- » The Ministry of Labor and Social Security is responsible for financing hospitals by granting a “hospital budget package”, the amount of which is set every year by the Finance Law. It determines which drugs are eligible for reimbursement, fixes the user fee and the price of medical services, and it organizes contracts with public or private health care providers. It also collects social insurance contributions and manages the health insurance funds (La Caisse Nationale des Assurances Sociales des Salariés), CNAS, and CAS-NOS (Caisse des Assurances Sociales des Non Salariés) (Social Security Law, 1983; Loi n° 83-11).

The general practitioner represents the entrance to the system at the level of primary health services, manages the patient’s file and supervises her/his care path.

## 5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTH CARE

### a. Major reform I

Name and type of legal act	Loi n° 83-11 du 2 juillet 1983 relatif aux assurances sociales (Law n° 83-11 of July 2, 1983 relating to social insurance)
Date the law was passed	July 2, 1983
Date of <i>de jure</i> implementation	July 5, 1983
Brief summary of content	The Law established a single social insurance scheme covering sickness, maternity, invalidity and death. It identifies categories of beneficiaries, types of benefits, financing and expenditure management (Lamri 2004). The aim was to unify the social security systems which were numerous and disparate at independence. Nowadays Social insurance covers all the risks mentioned in the law. The costs of preventive and curative care of the insured and his/her dependents are covered.
Socio-political context of introduction	The National Charter of 1976 and the Constitution in its article 67 underline the right to health protection of citizens, and free access to health care for the entire population. After the ordinance on free health care (Ordonnance n° 73-65) was passed, the financing of health from the state budget had become insufficient (Oufriha 1990). As a result, the social security organization became increasingly involved in health funding. The goal of the law of 1983 was to unify the different regimes (Merouani et al. 2014).

### b. Major reform II

Name and type of legal act	Loi n° 85-05 du 16 février 1985 relative à la protection et à la promotion de la santé (Law n° 85-05 of February 16, 1985 relating to the protection and promotion of health)
Date the law was passed	February 16, 1985
Date of <i>de jure</i> implementation	February 17, 1985



Brief summary of content	The law enshrines free health care in a health system subdivided into geographical "health sectors". All health services are free in public health facilities and include public health activities, health care, diagnostic procedures, treatment and hospitalization of patients. The organizational structure of the health system consists of geographical areas corresponding to that of the <i>Daira</i> covering about 100,000 inhabitants. The objective of the law is to protect and promote the health of the citizens within a planned national health system, taking into account the needs of the population of each region.
Socio-political context of introduction	Despite the free access to health care established in 1974, the health situation in the country didn't improve (Brahamia 1991). The political authorities of a centralized socialist state then adopted this law, to meet the needs of the population through an equitable distribution of health resources, and building an effective national health system. This strategy is based on the resolution of the Central Committee of FLN Party in 1980.

### c. Major reform III

Name and type of legal act	Décret exécutif n° 07-140 du 19 mai 2007 portant création, organisation et fonctionnement des établissements publics hospitaliers et des établissements publics de santé de proximité (Executive Decree n° 07-140 of May 19, 2007 on the creation, organization and operation of public hospitals and local public health establishments)
Date the law was passed	May 19, 2007
Date of <i>de jure</i> implementation	May 20, 2007
Brief summary of content	This decree put an end to "health sector" notion and aims to create, organize and operate public hospital establishments (EPH) and local public health establishments (EPSP). The latter consists of polyclinics and treatment rooms, covering a population pool. This represents a decentralization of the management of primary health care structures and introduces a new health map that adapts the decentralized provision of care to the growing demand for specialized care driven by the growing burden of non-communicable diseases, which are responsible for over 75 % of mortality. The old health centres were transformed into polyclinics, and are now equipped with diagnostic resources and specialist doctors to provide free basic care for patients with non-communicable diseases in addition to their prevention and primary care activity. If necessary, patients are referred to hospitals. The coverage rate is 1 polyclinic per 23,000 inhabitants in 2015 and 1.8 hospital beds per 1,000 inhabitants.
Socio-political context of introduction	The growing prevalence of non-communicable diseases put strong pressure on the existing hospital structures. Decentralization was becoming unavoidable. An exhaustive survey carried out by the Institut National de Santé Publique (National Institute of Public Health) in 2002 (INSP 2007), revealed that non-communicable diseases have become the leading causes of hospitalization and mortality. The 2007 reform is part of the objective of Universal Health Coverage declared by WHO. With the reform, screening for non-communicable diseases and necessary basic specialized care, has become available at the level of the EPSP.

## 6. DESCRIPTION OF CURRENT HEALTH CARE SYSTEM

### a. Organisational structure

Centralization of HCS system:

The Algerian health system is decentralized and hierarchical. It is made up of a public and a private sector. The state guarantees equitable access to health services, it “works to eliminate inequalities in access to health services, and organizes complementarity between the public and private health sectors.” (Loi n° 18-11, Art. 16).

The current (2020) overall social security contribution rate is 34.5 % of the basic salary. Health related social security contributions consist of an employer contribution (12.75 % of the employee’s salary) and an employee contribution of 1.5 % of his/her salary. Risks covered by the social security contribution are sickness, maternity, invalidity, work accidents and occupational diseases, death (CLEISS 2020).

General practitioners or referring doctors act as gatekeepers of the system: “Any patient has access, within the framework of the hierarchy of care, to specialized health services needed, on the referral of the referring physician, excepted the emergency cases and direct access medical cases defined by the Minister of Health. The referring physician is the general practitioner treating the patient at the level of the local public or private health facilities, closest to his home”. (Loi n° 18-11, Art. 22).

In 2018, 75.85 % of consultations took place in the EPSP (MSPRH 2018). A growing number of private health providers is concentrated in the northern urban centres.

Health care expenditures are financed through social insurance schemes and out-of-pocket payments. The government health budget finances training, research, and prevention measures, and health care for the poor. Social security covers about 85 % of the population. Children, chronically ill patients and low-income households have free access to health care. Local communities contribute to health financing with prevention and hygiene measures and health education programs. Coverage of private or complementary insurance schemes is insignificant.

#### Coverage

Percentage of population covered by government schemes	15 %
Percentage of population covered by the parafiscal social insurance scheme	85 %
Percentage of population covered by private schemes	negligible
Percentage of population uncovered	-

### b. Provision

	Value	Source
Physician density (per 1,000 inhabitants)	1.72	World Bank 2018
Density of nurses and midwives (per 1,000 inhabitants)	1.55	World Bank 2018
Hospital beds, public (per 1,000 inhabitants)	1.90	World Bank 2015
Hospital beds, privat/for profit (per 1,000 inhabitants)	0.14	MSPRH 2015

### c. Financing

Total expenditure for health (% of GDP)	6.22 %
Domestic general government health expenditure (% of current health expenditure)	65.83 %
Private expenditure on health (% of total expenditure on health)	34.14 %
Out-of-pocket expenditure (% of current health expenditure)	32.65 %
External health expenditure (% of current health expenditure)	0.027 %

Source: World Bank 2018

#### d. Regulation of dominant system

Actors responsible for regulation:

The Ministry of Health, Population and Hospital Reform (MSPRH) is responsible at the central level. At the local level (of the Wilaya) the respective Department of Health and Population is responsible for ensuring the application of legislation and regulations in all areas related to health and population activities.

Five health regions were created by the Ministry of Health and Population in 1995, each covering several Wilayat: the central health region with Algiers as its capital, the western health region with the regional capital Oran, the eastern health region with the regional capital Constantine, the south-western health region with Béchar, and the south-eastern health region with Ouargla. In each region, an advisory body, the Regional Health Council, exists, with the task of intersectoral coordination, and the promotion and protection of the health of the population under its jurisdiction.

The Ministry of Health decides on coverage standards and issues accreditation to practitioners wishing to open private health facilities.

The Ministry of Labor, Employment and Social Security, regulates access to the social security scheme, establishes the nomenclature of reimbursable drugs, and organizes contracts with public and private providers.

Public services package:

There is no fixed care package. Under § 13 of the 2018 Health Law, all health care is free in public health facilities for the entire population.

## 7. CO-EXISTING SYSTEMS

Beside the dominant public health care system, a para-public system of medical services belonging to the social security organization exists, that provides health care services to social insured persons and their families. In 2018 it comprises 1,640 practitioners. In addition, in public companies and administrations there are Medico Social Centers intended for prevention and occupational health.

Finally, there is a highly developed private for-profit health care sector, which employs 27.5 % of the doctors in Algeria in 2018, 53.3 % of the dentists and 85 % of the pharmacists, and comprises an extended network of clinics with more than 6,000 beds (Zehnati and Peyron 2015). Access to private care services is based on out-of-pocket payments. The prices of private providers medical acts are not regulated. Social security reimburses a tiny part of the costs incurred. Private insurance is very rare in Algeria. In 2018 Algerian households bear private health expenditure equal to around 30 % of total health expenditure (World Bank 2021 b).

The Ministry of Health regulates the practice of private health care providers, and gives agreement for opening clinics or pharmacies.

## 8. ROLE OF GLOBAL ACTORS

External actors do not play a relevant role in the provision of health care services or funding in Algeria. Sporadic contributions from the WHO or UNICEF are rare and negligible: 0.027 % of total health expenditure in 2018 (WB).

Some medical services are provided by Cuban doctors in specialized fields of health care where there a deficit of doctors in the public sector exists: ophthalmology, maternal and child health, oncology, urology (Presidential Decree No. 20-115 of May 6, 2020).

The WHO was active at the request of Algeria in support and expertise missions (MSPRH 2014). There are no external health charities.

## 9. LIST OF ADDITIONAL RELEVANT LEGAL ACTS

- Front de Libération Nationale. 1976. Charte Nationale, République Algérienne Démocratique et Populaire. <https://www.joradp.dz/Jo6283/1976/061/Fp714.pdf>.
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- Loi n° 83-11 du 2 juillet 1983 relatif aux assurances sociales. Journal Officiel de la République Algérienne n° 28 du 05.07.1983.
- Loi n° 85-05 du 16 février 1985 relative à la protection et à la promotion de la santé, Journal Officiel de la République Algérienne n° 8 du 17.02.1985.
- Décret exécutif n° 07-140 du 19 mai 2007 portant création, organisation et fonctionnement des établissements publics hospitaliers et des établissements publics de santé de proximité. Journal Officiel de la République Algérienne n° 33 du 20.05.2007.
- Loi n° 18-11 du 2 juillet 2018 relative à la santé. Journal Officiel de la République Algérienne n° 46, du 29.07.2018.
- Décret Présidentiel n° 20-115 du 06 Mai 2020 Portant ratification de la convention relative aux modalités de mise en oeuvre de la coopération dans le domaine de la santé entre le Gouvernement de la République algérienne démocratique et populaire et le Gouvernement de la République de Cuba, signée à La Havane, le 30 janvier 2018 2020. Journal Officiel de la République Algérienne n° 30 du 21.05.2020.
- Décret Présidentiel n° 20-158 du 13 Juin 2020 Portant création d'une agence nationale de sécurité sanitaire. Journal Officiel de la République Algérienne n° 35 du 14.06.2020.

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